Bureau of Health Care Quality and Compliance

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/G		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE S COMPL			
				A. BUILDING					
		NVS5460AGC		B. WING		11	/08/2010		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE				
GOLDEN SUNSHINE HOME				8333 JEREMIAH LODGE AVE LAS VEGAS, NV 89131					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
Y 000	Initial Comments			Y 000					
	by the Health Division prohibiting any criminactions or other clair	nclusions of any investig on shall not be construed nal or civil investigations ns for relief that may be y under applicable feder	d as s,						
	This Statement of Deficiencies was generated as a result of an annual State Licensure survey and a complaint investigation conducted in your facility on 10/21/10 to 11/8/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility received the grade of D. The facility is licensed for 10 Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was seven. Seven resident files were reviewed and four employee files were reviewed. One discharged resident file was reviewed.		and nority						
			ns nts. even.						
	Complaint #NV0002 Tag Y9999.	6725 was substantiated	. See						
	The following deficie	ncies were identified:							
Y 072 SS=E		lifications of Caregiver-I	Med	Y 072					
	facility in the administ medication, including over-the-counter me supplement, the care (a) Before assisting a	g, without limitation, an dication or dietary egiver must:	ential						

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

	TATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		` ,	(X3) DATE SURVEY COMPLETED	
		NVS5460AGC		B. WING		11/	08/2010	
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE			
GOLDEN	SUNSHINE HOME			MIAH LODGE S, NV 89131	AVE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
Y 072	training required purs subsection 6 of NRS at least 16 hours of training classroom training an practical training, and acknowledging the correction (b) Receive annually in the management or provide the residential evidence of the content her attendance at the (c) Complete the train the administrator of training training to paragraph 449.2742; and	uant to paragraph (e) of 449.037, which must in aining in the managem of not less than 12 hord not less than 4 hours obtain a certificate impletion of such training at least 8 hours of trair femedication and I facility with satisfactor int of the training and histraining; ing program developed in (e) of subsection 1 of	clude ent of urs of of ng; ning ty is or they NAC	Y 072				
	Based on record revie failed to ensure that 1 completed the require management refreshe (Employee #4).	ed three hour medication or training every three y	ility n vears					
	State Licensure surve	iciency from the 10/20/ ey.	Uð					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		NVS5460AGC		B. WING		11/0	8/2010
	OVIDER OR SUPPLIER		8333 JERE	RESS, CITY, STA MIAH LODGE S, NV 89131		, , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FU .SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
Y 072	Continued From page	2		Y 072			
	Severity: 2 Scope: 2						
Y 103 SS=E	449.200(1)(d) Person Tuberculosis	nel File - NAC 441A /		Y 103			
	a separate personnel member of the staff of	e provided in subsection file must be kept for east a facility and must incontest required pursuant for the employee.	ıch lude:				
	Based on record reviet failed to ensure 2 of 4 NAC 441A.375 regard testing for the protecti (Employee #2 - failed positive TB test or an symptoms form, and a symptom form, and a symptoms form, and a symptoms form, and a symptom form, and a s	on of all residents to provide evidence of	ility vith a ence				
	This was a repeat def State Licensure surve	iciency from the 10/20/	09				
	Severity: 2 Scope: 2	2					
Y 105 SS=E	449.200(1)(f) Personr	nel File - Background C	heck	Y 105			
	a separate personnel	e provided in subsectio file must be kept for ea f a facility and must inc	ich				

	MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM					(X3) DATE SURVEY COMPLETED	
		NVS5460AGC		B. WING		11/0	8/2010
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		0/2010
GOLDEN	SUNSHINE HOME			MIAH LODGE S, NV 89131	AVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
Y 105	Continued From page 3			Y 105			
	(f) Evidence of compl 449.185, inclusive.	iance with NRS 449.17	6 to				
	Based on record reviet failed to ensure 1 of 4 background check ret to 449.188 (Employee	quirements of NRS 449	ility .176				
	•	This was a repeat deficiency from the 10/20/09 State Licensure survey.					
	Severity: 2 Scope: 2	2					
Y 251 SS=F	449.217(2) Storage o refrigerated	f Food-Perishable food	s	Y 251			
	temperature of 40 deg	nust be refrigerated at a grees Fahrenheit or les e kept at a temperature	S.				
	Based on observation failed to ensure the retemperature of 40 degrees.	ot met as evidenced by: n on 2/26/09, the facility efrigerator maintained a grees Fahrenheit or les ded a reading of 50 deg 9.	, S.				
	Severity: 2 Scope	: 3					

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		NVS5460AGC		B. WING		11/08	3/2010
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	ATE, ZIP CODE	•	
GOLDEN	SUNSHINE HOME			MIAH LODGE S, NV 89131	AVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
Y 274	Continued From page	2 4		Y 274			
Y 274 SS=C	449.2175(5) Service of Food - Substitutions			Y 274			
	be documented and k at least 90 days after	or an item on the menu sept on file with the mer the substitution occurs posted in a conspicuous ce of the meal.	nu for . A				
	This Regulation is not met as evidenced by: Based on observation and interview on 10/21/10, the facility failed to ensure menu substitutions were documented and retained for at least 90 days.		1/10, s				
	Severity: 1 Sco	ope: 3					
Y 450 SS=E	449.231(1) First Aid a	and CPR		Y 450			
	NAC 449.231 1. Within 30 days after administrator or caregoresidential facility is enthe facility, the administrator must be trained cardiopulmonary advanced certificate in adult cardiopulmonary issued by the America equivalent certification accepted as proof of the second control of the second care and cardiopulmonary issued by the America equivalent certification accepted as proof of the second care and careful care	giver of a mployed at instrator or ined in first aid resuscitation. The in first aid and y resuscitation an Red Cross or an in will be					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		NVS5460AGC			·	11/0	8/2010	
NAME OF PR	OVIDER OR SUPPLIER	111001001100	STREET ADD	I RESS, CITY, STA	TE, ZIP CODE	1170	0/2010	
	SUNSHINE HOME		8333 JERE	8333 JEREMIAH LODGE AVE LAS VEGAS, NV 89131				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
Y 450	Continued From page	e 5		Y 450				
Y 530 SS=F	Based on record revidid not ensure that 1 aid training within thin (Employee #3). This was a repeat de State Licensure surve Severity: 2 Scope:	2	ility d first	Y 530				
	. ,	sidents at least 10 hour lled activities that are su capacities.						
	_							
	Severity: 2 Scope:	3						
Y 620 SS=D	449.2702(4)(a) Admi:	ssion Policy		Y 620				
	and 449.2754, a resid	se provided in NAC 449 dential facility shall not a the facility any person v	admit					

	MENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER			(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		NVS5460AGC		B. WING		11/08	8/2010
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE	•	
GOLDEN	SUNSHINE HOME		8333 JEREN LAS VEGAS	MIAH LODGE s, NV 89131	AVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
Y 620	Continued From page	e 6		Y 620			
	(a) Is bedfast.						
Y 621 SS=E	This Regulation is not NAC 449.2702 6. As used in this sect (a) "Bedfast" means a person is:	a condition in which a nanging his position in the of another person; or ew, observation and the facility admitted a dfast (Resident #3). 1 2 sion Policy 2 e provided in NAC 449 3 dential facility shall not a side facility any person when a side of the facility any person when and the facility any person when any person w	oed .275 admit	Y 621			
	This Regulation is no NAC 449.2702 6. As used in this sec (b) "Restraint" means						

	OF DEFICIENCIES F CORRECTION		1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		NVS5460AGC		B. WING		11/0	8/2010
NAME OF PF	ROVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE		
GOLDEN SUNSHINE HOME			8333 JEREMI LAS VEGAS,		AVE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
Y 621	for discipline or conveto treat medical symp (2) A manual meth resident's freedom of access to his body; or (3) A device or mattached to or adjacer cannot be removed expected to the resident's his normal access to be assed on observation review on 10/21/10, the	macologic drug that is usenience and is not requitoms; od for restricting a movement or his normaterial or equipment which to a resident's body the resident and freedom of movement his body. In interview and recording facility failed to ensubtrestrained with the usenience and is restrained with the usenience and is not restrained with the usenience and is not restrained with the usenience and is not restrained.	used ired al ch is hat d cor	Y 621			
Y 645 SS=C	NAC 449.2704 The administrator of a upon request, make the available in writing: 1. The basic rate for the facility; 2. The schedule for parameters of the Services included. The charges for opnot included in the basic rate of the schedule for parameters of the schedule for param	a residential facility shal the following information the services provided by ayment; ded in the basic rate; tional services which and sic rate; and lity's policy on refunds of	II, n y the	Y 645			

AND DIAN OF CODDECTION		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		NVS5460AGC		B. WING		11	08/2010
NAME OF PF	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STAT	E, ZIP CODE		
GOLDEN	SUNSHINE HOME			EMIAH LODGE A S, NV 89131	VE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FI OR LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
Y 645	Continued From pa	age 8		Y 645			
	Based on record refailed to provide a	not met as evidenced by eview on 10/21/10, the factoriate agreement for 5 of 7 t #1, #2, #5, #6 and #7).	cility				
Y 680 SS=G	NAC 449.271 Except as otherwise provided in NAC 449.273 person must not be admitted to a residential facility or permitted to remain as a resident of a residential facility if he: 1. Requires gastrostomy care.			Y 680			
			l				
	Based on interview 10/21/10, the facilit	not met as evidenced by and record review on by admitted and retained a red care of a gastrostomy	а				
	Findings include:						
	was admitted to the gastrostomy tube (orders in the file for	nt #3 revealed that the rese facility on 8/25/10 with a g-tube). There were physic home health nursing seles the and for medications gh the g-tube.	a sician rvices				
	a home health age three times per day	egivers revelaed a nurse ncy presented to the facil to administer medication the resident's g-tube.	lity ns				

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE					(X3) DATE SURVEY COMPLETED	
		NVS5460AGC		B. WING		11	/08/2010
NAME OF PR	OVIDER OR SUPPLIER	117001001100	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		700/2010
GOLDEN	SUNSHINE HOME			MIAH LODGE S, NV 89131	AVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
Y 680	Continued From page	9		Y 680			
	resident was unable t		e				
	Severity: 3 Scope:	1					
Y 740 SS=D	449.272(1)(a)-(c) Indwelling Catheter			Y 740			
	catheter must not be a facility or be permitted a residential facility up (a) The resident is phocapable of caring for a with or without the assemble of the canaccordance with the particular provide that care. (c) The catheter is instaccordance with the canaccordance with t	ysically and mentally all aspects of the condisistance of a caregiver, theter is performed in physician's orders by a who has been trained the trained and removed only orders of a physician by who has been trained to the trained to	al nt of tion,				
	Based on interview ar 10/21/10, the facility a resident who was not	of met as evidenced by: and record review on admitted and retained a mentally capable of ca andwelling catheter (Res	ı ring				

AND DIAN OF CODDECTION		, ,	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		SURVEY ETED
		NVS5460AGC	ı	B. WING		11/	/08/2010
	ROVIDER OR SUPPLIER SUNSHINE HOME		8333 JERE	8333 JEREMIAH LODGE AVE LAS VEGAS, NV 89131			
(X4) ID PREFIX TAG	(EACH DEFICIE	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FI REGULATORY OR LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
Y 740 Y 743	#3).	Scope: 1		Y 740			
SS=F	facility with a reside indwelling catheter (a) The bag and tulchanged by: (1) The resident assistance of a car (2) A medical pretrained to provide to the disposed of proper (c) Privacy is afford being provided; and (d) The bag of the caregiver who has handling of such well as the term of the	bing of the catheter are t, with or without the egiver. rofessional who has been hat care. use of the catheter is ly. led to the resident while of	of an				
	Based on observat the facility failed to residents (Residen catheter complied #1, #3 and #4 failed	not met as evidenced by ion and interview on 10/2 ensure the caregivers of t #3), who had an indwell with NAC 449.272. Emplod to have evidence of traitymptoms of urinary tract dration.	1/10, 1 of 1 ing oyee				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		NVS5460AGC		B. WING			8/2010
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	1	5/10/10
GOLDEN	SUNSHINE HOME			MIAH LODGE S, NV 89131	AVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
Y 743	Continued From page	e 11		Y 743			
	Severity: 2 Scope: 3						
Y 859 SS=E	449.274(5) Periodic Physical examination of a resident			Y 859			
	NAC 449.274 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his physician. The resident must be cared for pursuant to any instructions provided by the resident's physician.						
	This Regulation is not met as evidenced by: Based on record review on 10/21/10, the facility failed to ensure that 1 of 7 residents received an annual physical (Resident #4), and 1 of 7 residents received a physical prior to admission (Resident #6).		ility d an				
	This was a repeat def State Licensure surve	ficiency from the 10/20/ ey.	09				
	Severity: 2 Scope: 2	2					
Y 883 SS=D	449.2742(7) Medicati	on / Resident Refusal		Y 883			
		s, or otherwise misses, lication, a physician mu					

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		NVS5460AGC		B. WING		11/08/2010		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	ATE, ZIP CODE			
GOLDEN SUNSHINE HOME			8333 JEREMI LAS VEGAS,		AVE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION (X5) CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE		
Y 883	Continued From page 12 notified within 12 hours after the dose is refused or missed. This Regulation is not met as evidenced by: Based on interview on 10/21/10, the facility failed to ensure the physician was notified with in 12 hours after a medication was missed or refused for 1 of 7 Residents. Employee #1 stated Resident #5 refused her medications regularly, however the facility failed to notify the physician. Severity: 2 Scope: 1		ailed 2 sed	Y 883				
Y 941 SS=C	Y 941 449.2749(1)(h) Resident file - Facility Rules		ch for at ece st	Y 941				

AND PLAN OF CORRECTION IDENTIFICATION N		(X1) PROVIDER/SUPPLIER/O	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		NVS5460AGC		A. BUILDING B. WING		11/08/2010		
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		00.2010	
GOLDEN SUNSHINE HOME			8333 JEREMIAH LODGE AVE LAS VEGAS, NV 89131					
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	(X5) COMPLETE DATE			
Y 941	Continued From pag		Y 941					
	This Regulation is not met as evidenced by: Based on record review on 10/21/10, the facility failed to have the rules of the facility signed by th administrator of the facility and 5 of 7 residents (Resident #1, #2, #5, #6 and #7). Severity: 1 Scope: 3							
Y1035 SS=F	Y1035 449.2768(1)(a)(1) Dementia Training			Y1035				
33-1								
	Based on record rev failed to ensure 4 of	ot met as evidenced by iew on 10/21/10, the fac 4 caregivers (Employee ved 2 hours of training v work at the facility.	cility ± #1,					
	This was a repeat de State Licensure surv	eficiency from the 10/20/	/09					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
NVSEAROAGO		NVS5460AGC		B. WING		11/0	8/2010		
NAME OF PROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		.0.2010		
GOLDEN SUNSHINE HOME				333 JEREMIAH LODGE AVE AS VEGAS, NV 89131					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	CTION SHOULD BE COMPLET O THE APPROPRIATE DATE			
Y1035	Continued From page 14			Y1035					
	Severity: 2 Scope: 3								
Y1036 SS=F	449.2768(1)(a)(2) Dementia Training			Y1036					
	449.2768 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which provides care to persons with any form of dementia shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer's disease, successfully completes: (2) In addition to the training requirements set forth in subparagraph (1), within 3 months after such an employee is initially employed at the facility, at least 8 hours of training in providing care to a resident with any form of dementia, including, without limitation, Alzheimer's disease.								
	Based on record revie failed to ensure that a training related to the with Alzheimer's was	ot met as evidenced by: ew on 10/21/10, the fact minimum of 8 hours of care of residents diagr received within 90 days rers (Employee #1, #2,	cility f nosed s of						
	Severity: 2 Scope:	3							
Y9999	Final Observations			Y9999					
	NRS 449.0355 Super	vision of residential fac	cility						

NVS5460AGC NAME OF PROVIDER OR SUPPLIER B. WING	/2010
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN SUNSHINE HOME 8333 JEREMIAH LODGE AVE LAS VEGAS, NV 89131	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y9999 Continued From page 15 Y9999	
for groups. A residential facility for groups must not be operated except under the supervision of an administrator of a residential facility for groups licensed pursuant to the provisions of chapter 654 of NRS. Based on observation and interview on 10/21/10, the facility failed to have evidence it employed a licensed administrator. Severity: 2 Scope: 3	